Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 07/17/01.
   b. The request was received on 06/06/02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60 and Position Statement located on the Table of Disputed Services
   b. HCFAs-1450
   c. TWCC 62 form/Medical Audit
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II: No Response

3. The Commission requested two copies of additional documentation via a Fee letter mailed to the Requestor on 07/12/02 in accordance with Rule 133.307 (g) (3). The provider did not respond per the rule. The case file does not contain a carrier sign sheet. The carrier did not submit any response to the request for medical dispute resolution. The "No Response Submitted" sheet is reflected as Exhibit II of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Table of Disputed Services
   "According to Rule 134.401 (a) Applicability (4) of the Texas Workforce Commission, there are no fee schedules for outpatient treatment at a hospital facility. The payor has applied Medical Fee Guideline rates FOR PHYSICIANS. We believe our charges are fair and reasonable and no discount should apply."

2. Respondent: No Response

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 07/17/01.

2. The carrier denied the billed charges by denial code, "M – THE REIMBURSEMENT FOR THE SERVICE RENDERED HAS BEEN DETERMINED TO BE FAIR AND REASONABLE BASED ON BILLING AND PAYMENT RESEARCH AND IS IN ACCORDANCE WITH LABOR CODE 413.011 (B)."

3. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer. Per the provider's TWCC-60, the amount billed is $131.00; the amount paid is $41.00; the amount in dispute is $90.00. The medical audit dated 02/06/02 states, "The carrier allowed fair and reasonable reimbursement for service rendered."

4. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
07/17/01	73610	$131.00	$41.00	M	No MAR	Acute Care Inpatient Hospital Fee Guidelines Rule 134.401 (a) (3), (c) (4); Rule 133.307 (g) (3) (D); CPT Descriptor	CPT Code 73610 – Radiologic exam of the ankle, complete minimum of three views was rendered in a hospital radiology department, not a physician's office. Therefore, these Codes are subject to the Acute Care Inpatient Hospital Fee Guidelines (ACIHFG), Rule 133.304 (a) (3), which states radiological services "..shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific services." Rule 133.307 (g) (3) (D) places certain requirements on the provider when supplying documentation with the request for dispute resolution. The provider is to discuss, demonstrate, and justify that the payment amount being sought is fair and reasonable. As the requestor, the health care provider has the burden to prove that the fees paid were not fair and reasonable. The provider has not submitted any documentation to support this; therefore **no** additional reimbursement is recommended.
Totals		$131.00	$41.00				The Requestor **is not** entitled to reimbursement.

The above Findings and Decision are hereby issued this 5th day of March 2003.

Donna M. Myers
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm